		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031385

Facility Name: SKOKIE MEADOWS N CENTER #1

Address: 9615 N. KNOX AVE. (Number) SKOKIE (City) 60076 (Zip Code)

County: COOK

Telephone Number: (847) 679-4161 **Fax #** (847) 329-8633

IDPA ID Number: 36-3481217

Date of Initial License for Current Owners: 03/23/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JACOB GRAFF
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	113	Skilled (SNF)	113	41,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,326	2,326	8
9	SNF/PED					9
10	ICF	31,941	1,464	3,621	37,026	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,941	1,464	5,947	39,352	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.41%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/23/88

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 3/23/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,326

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	234,601	10,385	9,975	254,961		254,961		254,961			1
2	Food Purchase		139,773		139,773	(18,798)	120,975		120,975			2
3	Housekeeping	125,784	15,339		141,123		141,123		141,123			3
4	Laundry	64,565	21,154		85,719		85,719		85,719			4
5	Heat and Other Utilities			103,205	103,205		103,205	241	103,446			5
6	Maintenance		13,837	33,497	47,334		47,334	1,691	49,025			6
7	Other (specify):* SCAVENGER			12,999	12,999		12,999		12,999			7
8	**TOTAL General Services**	424,950	200,488	159,676	785,114	(18,798)	766,316	1,932	768,248			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,770,303	42,793	68,195	1,881,291		1,881,291		1,881,291			10
10a	Therapy	22,577		5,461	28,038		28,038		28,038			10a
11	Activities	88,529	10,175		98,704		98,704		98,704			11
12	Social Services	119,224		4,029	123,253		123,253		123,253			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,000,633	52,968	78,885	2,132,486		2,132,486		2,132,486			16
	C. General Administration											
17	Administrative	102,945		474,607	577,552		577,552	(447,239)	130,313			17
18	Directors Fees											18
19	Professional Services			59,431	59,431		59,431	1,205	60,636			19
20	Dues, Fees, Subscriptions & Promotions			71,738	71,738		71,738	(51,653)	20,085			20
21	Clerical & General Office Expenses	117,085	16,994	271,589	405,668		405,668	(156,911)	248,757			21
22	Employee Benefits & Payroll Taxes			409,761	409,761	18,798	428,559		428,559			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,010	14,010		14,010	(12,258)	1,752			24
25	Other Admin. Staff Transportation			12,767	12,767		12,767		12,767			25
26	Insurance-Prop.Liab.Malpractice			136,829	136,829		136,829		136,829			26
27	Other (specify):*							16,296	16,296			27
28	**TOTAL General Administration**	220,030	16,994	1,450,732	1,687,756	18,798	1,706,554	(650,560)	1,055,994			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,645,613	270,450	1,689,293	4,605,356		4,605,356	(648,628)	3,956,728			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SKOKIE MEADOWS N CENTER #1 **#0031385** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,975	
	REPAIRS & MAINTENANCE		0	
			0	9,975
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		45,610	
	ELECTRICITY		28,582	
	WATER		24,561	
	CABLE TV - LOBBY		4,452	
			0	103,205
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,590	
	PAINTING & DECORATING		537	
	BUILDING REPAIRS		1,355	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12,247	
	ELEVATOR MAINTENANCE & REPAIR		3,094	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,250	
	FIRE SERVICE		4,424	
			0	
			0	
			0	33,497
7	**OTHER**			
	SCAVENGER		12,999	
	SECURITY SERVICE		0	12,999
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,200	1,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	5,702	
	LABORATORY & XRAY EXPENSE		9,262	
	PURCHASED SERVICES		24,226	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128	
	PHARMACY CONSULTANT	XVIII B 39-2	1,452	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	16,500	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		6,925	
			0	68,195
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	5,461	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	5,461
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,029	
			0	4,029
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 **#0031385** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	474,607	474,607
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,249	
	ADMINISTRATIVE CONSULTANTS	XIX C	2,500	
	PROFESSIONAL FEES	XIX C	44,682	
			0	59,431
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	37,158	
	EMPLOYEE WANT ADS	XIX F	8,859	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	8,166	
	LICENSES & PERMITS	XIX F	960	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	12,784	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,711	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,100	71,738
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,223	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		256,900	
	PENALTIES / OVERDRAFT CHARGES	VI 18	771	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,695	
	MESSENGER SERVICE		0	
			0	271,589

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	199,341	
	UNEMPLOYMENT COMPENSATION	XIX D	16,118	
	WORKERS COMPENSATION INSURANCI	XIX D	34,681	
	HOSPITALIZATION INSURANCE	XIX D	129,393	
	EMPLOYEE BENEFITS - OTHER	XIX D	29,903	
	EMPLOYEE PHYSICAL EXAMS	XIX D	325	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	409,761
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,752	
	TRAVEL	XIX G		
	NON-ALLOWABLE TRAVEL		12,258	
			0	14,010
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,767	12,767
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		136,829	136,829
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,689,293

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 #0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			45,550	45,550		45,550	100,187	145,737			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,491	55,491		55,491	478,353	533,844			32
33	Real Estate Taxes			162,607	162,607		162,607		162,607			33
34	Rent-Facility & Grounds			528,748	528,748		528,748	(528,748)				34
35	Rent-Equipment & Vehicles			44,911	44,911		44,911	4,054	48,965			35
36	Other (specify):*											36
37	**TOTAL Ownership**			837,307	837,307		837,307	53,846	891,153			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,000	161,359	287,359		287,359		287,359			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,868	61,868		61,868		61,868			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		126,000	223,227	349,227		349,227		349,227			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,645,613	396,450	2,749,827	5,791,890		5,791,890	(594,782)	5,197,108			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,590	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(771)	21		18
19	Entertainment		20		19
20	Contributions	(1,711)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(37,158)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,784)	20		28
29	Other-Attach Schedule	(12,790)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,624)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(531,158)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (531,158)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (594,782)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SKOKIE MEADOWS N CENTER #1

ID# 0031385

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,691	6	1
2	NON-ALLOWABLE TRAVEL	(12,258)	24	2
3	BANK CHARGES	(2,223)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,790)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	241	0	0	0	0	0	0	0	0	0	241	5
6	Maintenance	1,691	0	0	0	0	0	0	0	0	0	0	1,691	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,691	241	0	0	0	0	0	0	0	0	0	1,932	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(447,239)	0	0	0	0	0	0	0	0	0	(447,239)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,205	0	0	0	0	0	0	0	0	0	1,205	19
20	Fees, Subscriptions & Promotions	(51,653)	0	0	0	0	0	0	0	0	0	0	(51,653)	20
21	Clerical & General Office Expenses	(2,994)	(153,917)	0	0	0	0	0	0	0	0	0	(156,911)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(12,258)	0	0	0	0	0	0	0	0	0	0	(12,258)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	16,296	0	0	0	0	0	0	0	0	0	16,296	27
28	**TOTAL General Administration**	(66,905)	(583,655)	0	0	0	0	0	0	0	0	0	(650,560)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,214)	(583,414)	0	0	0	0	0	0	0	0	0	(648,628)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	1,590	0	98,597	0	0	0	0	0	0	0	0	100,187	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	478,353	0	0	0	0	0	0	0	0	478,353	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(528,748)	0	0	0	0	0	0	0	0	(528,748)	34
35	Rent-Equipment & Vehicles	0	4,054	0	0	0	0	0	0	0	0	0	4,054	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,590	4,054	48,202	0	0	0	0	0	0	0	0	53,846	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,624)	(579,360)	48,202	0	0	0	0	0	0	0	0	(594,782)	45

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFF	100	SKOKIE MEADOWS II	SKOKIE	PREMIER	SKOKIE	BOOKKEEPING
		MOMENCE MEADOWS	MOMENCE	MANAGEMENT		MANAGEMENT
		SHELDON MEADOWS	SHELDON			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 474,607	PREMIER MANAGEMENT		$	$ (474,607)	1
2	V	21	OUTSIDE CLERICAL SVC	232,500	PREMIER MANAGEMENT			(232,500)	2
3	V	21	OUTSIDE SERVICES	24,400	1139 BEVERLY			(24,400)	3
4	V	5	UTILITIES		PREMIER MANAGEMENT		241	241	4
5	V	17	OFFICER SALARIES		PREMIER MANAGEMENT		27,368	27,368	5
6	V	19	PROFESSIONAL FEES		PREMIER MANAGEMENT		1,205	1,205	6
7	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		12,996	12,996	7
8	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		28,249	28,249	8
9	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		48,069	48,069	9
10	V	21	CLERICAL		PREMIER MANAGEMENT		13,669	13,669	10
11	V	27	PAYR. TAXES/HEALTH INS				16,296	16,296	11
12	V	35	OFFICE RENTAL				4,054	4,054	12
13	V								13
14	Total			$ 731,507			$ 152,147	$ * (579,360)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 528,748	M O SKOKIE MEADOWS	100.00%	$	$ (528,748)	15
16	V	30	DEPRECIATION				98,597	98,597	16
17	V	32	INTEREST				478,353	478,353	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 528,748			$ 576,950	$ * 48,202	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	Administrative,	100.00	Momence-$23,446			Salary	$ 27,368	17-7	1
2			Banking,Finance		Skokie 2-$27,571						2
3					Sheldon-$7,384						3
4					Cal,Homes-$74,231						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,368		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 679-7733
Fax Number: (847) 679-7736

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	230,059	5	$ 1,409	$	39,352	$ 241	1
2	17	OFFICER SALARIES	PER RESIDENT DAY	230,059	5	160,000	160,000	39,352	27,368	2
3	19	PROFESSIONAL FEES	PER RESIDENT DAY	230,059	5	7,047		39,352	1,205	3
4	21	CLERICAL SALARIES	DIRECT	10	4	43,320	43,320	3	12,996	4
5	21	CLERICAL SALARIES	DIRECT	4	3	112,996	112,996	1	28,249	5
6	21	CLERICAL SALARIES	PER RESIDENT DAY	230,059	5	281,019	281,019	39,352	48,069	6
7	21	CLERICAL	PER RESIDENT DAY	230,059	5	79,909		39,352	13,669	7
8	27	PAYR. TAXES/HEALTH INS	PER RESIDENT DAY	230,059	5	95,272		39,352	16,296	8
9	35	OFFICE RENTAL	PER RESIDENT DAY	230,059	5	23,699		39,352	4,054	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 804,671	$ 597,335		$ 152,147	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: M O SKOKIE MEADOWS NURSING
Street Address: 9615 N KNOX
City / State / Zip Code: SKOKIE,IL 60076
Phone Number: (847)679-7733
Fax Number: (847)679-7734

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 98,597	$	1	$ 98,597	1
2	32	INTEREST	DIRECT	1	1	478,353		1	478,353	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 576,950	$		$ 576,950	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	CAMBRIDGE		X	MORTGAGE	$44,062.00	8/16/01	6,822,050	6,714,117	8/16/36	0.0710	478,353	2
3												3
4												4
5												5
	Working Capital											
6	1 ST EQUITY		X	WORKING CAPITAL	INT ONLY			757,558			37,973	6
7	SHAREHOLDER LOAN	X								0.0400	17,518	7
8												8
9	TOTAL Facility Related				$44,062.00		$ 6,822,050	$ 7,471,675			$ 533,844	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,822,050	$ 7,471,675			$ 533,844	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 156,179	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 159,393	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,214	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 159,393	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 162,607	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	169,897	8
	1999	171,674	9
	2000	176,544	10
	2001	156,179	11
	2002	159,393	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKOKIE MEADOWS N CENTER #1 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031385

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-304-042-0000	NURSING HOME	$ 159,392.65	$ 159,392.65
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 159,392.65	$ 159,392.65

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,048 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING		1990	$ 347,575	1
2					2
3	TOTALS			$ 347,575	3

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		90		$ 1,968,925	$ 62,506	31.5	$ 62,506	$	$ 773,530	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENT			1987	4,888	155	20	155		3,682	9
10	IMPROVEMENT			1988	3,196	101	31.5	101		1,590	10
11	IMPROVEMENT			1990	29,530	937	31.5	937		12,233	11
12	IMPROVEMENT			1991	20,962	665	31.5	665		8,342	12
13	IMPROVEMENT			1992	18,635	593	31.5	593		6,773	13
14	IMPROVEMENT			1993	50,200	1,594	31.5	1,594		17,327	14
15	IMPROVEMENT			1993	8,052	206	39	206		2,137	15
16	IMPROVEMENT			1994	71,864	1,843	39	1,843		17,624	16
17	FIRE DAMPERS			1995	4,980	128	39	128		1,136	17
18	NURSE STATION REMODELING			1995	70,129	1,798	39	1,798		15,209	18
19	CONCRETE WORK, PATIO, RAMPS			1995	21,904	1,460	39	1,460		12,593	19
20	RESIDENT ROOM REMODELING			1996	25,459	653	15	653		4,979	20
21	ROOF			1996	1,200	31	39	31		248	21
22	REHABBING 1ST FLOOR CORRIDOR LOWER WALLS			1997	14,497	372	39	372		2,434	22
23	DOOR			1997	1,455	37	39	37		257	23
24	ELEVATOR RENOVATION			1997	14,791	379	39	379		2,321	24
25	FIRE DAMPERS			1998	7,282	187	39	187		1,098	25
26	EXHAUST FANS			1998	4,135	106	39	106		599	26
27	FIRE DAMPERS & 21 GRILLS			1998	22,408	575	39	575		3,231	27
28	ACCESS PANELS & FIRE DAMPERS			1998	2,720	70	39	70		359	28
29	TILING			1999	14,344	368	39	368		1,671	29
30	KIL-BAR			1999	3,587	92	39	92		418	30
31	WALL HEATERS			1999	6,392	164	39	164		745	31
32	DOOR			1999	1,190	30	39	30		137	32
33	WINDOW REPLACEMENT			1999	61,410	1,575	39	1,575		7,153	33
34	SHOWER ROOM TILING			1999	9,206	236	39	236		1,072	34
35	GENERATOR			2000	62,880	2,287	27.5	2,287		8,004	35
36	TILING			2000	6,052	220	27.5	220		770	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALL COVERING	2000	$ 33,819	$ 4,224	7	$ 4,831	$ 607	$ 20,619	37
38	AWNING	2001	2,951	107	27.5	107		272	38
39	CORNICES	2001	1,741	63	27.5	63		160	39
40	ROOF	2001	50,988	1,854	27.5	1,854		4,712	40
41	DOOR	2001	2,160	79	27.5	79		201	41
42	ELEVATOR DOOR	2001	10,450	380	27.5	380		966	42
43	TWO DECK ROOFS	2001	12,100	440	27.5	440		1,118	43
44	5 TON CONDENSING UNIT	2001	2,854	104	27.5	104		264	44
45	WALLPAPERING, PAINTING	2002	60,000	13,440	5	12,000	(1,440)	18,000	45
46	FLORIDA SMOKING ROOM	2002	27,967	1,017	27.5	1,017		1,568	46
47	DUCTLESS SPLIT ROOM	2002	12,377	450	27.5	450		694	47
48	VALVE	2002	2,160	78	27.5	78		121	48
49	SIGN	2002	2,450	163	15	163		245	49
50	SHEET LEAD SHOWER LINER PANS	2002	5,471	199	27.5	199		307	50
51	SHOWER BASIN TILING	2002	15,498	564	27.5	564		869	51
52	PAVING PARKING LOT	2002	12,495	833	15	833		1,249	52
53	CONCRETE FOOTINGS, WALLS, STEPS,	2002	29,975	1,090	27.5	1,090		1,680	53
54	COOLER DOOR	2002	3,772	137	27.5	137		211	54
55	SIGN	2002	4,590	306	15	306		459	55
56	TUCKPOINTING	2002	24,600	894	27.5	894		1,379	56
57	4 TON CONDENSING UNIT	2002	4,800	175	27.5	175		269	57
58	VCT,COVE BASE	2003	4,639	91	27.5	91		91	58
59	ELEVATOR SAFETY EDGE	2003	1,575	31	27.5	31		31	59
60	NURSE CALL SYSTEM	2003	4,596	91	27.5	91		91	60
61	CARPET	2003	1,752	771	5	350	(421)	350	61
62	BLINDS	2003	2,648	1,589	5	530	(1,059)	530	62
63	CUBICLE CURTAINS, PAINTING,WALLPAPER	2003	5,805	3,483	5	1,161	(2,322)	1,161	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,876,506	$ 112,021		$ 107,386	$ (4,635)	$ 965,289	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 450,067	$ 21,919	$ 37,321	$ 15,402	10	$ 291,191	71
72	Current Year Purchases	20,590	10,207	1,030	(9,177)	10	1,030	72
73	Fully Depreciated Assets	335,931					335,931	73
74								74
75	TOTALS	$ 806,588	$ 32,126	$ 38,351	$ 6,225		$ 628,152	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,030,669	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 144,147	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 145,737	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,590	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,593,441	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 21,445 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	2002 ECOCO VAN E350	$ 555.00	$ 6,680	17
18	ADMINISTRATOR	2001 OLDS ALERO	472.00	5,665	18
19	ADMINISTRATOR	2002 CADILLAC	927.00	11,121	19
20					20
21	TOTAL		$ #######	$ 23,466	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 60,918	$		$ 60,918	1
2	Licensed Speech and Language Development Therapist		hrs			9,164			9,164	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			91,277			91,277	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				126,000		126,000	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 161,359	$ 126,000		$ 287,359	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,721,966	$	1
2	Cash-Patient Deposits	3,457		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,416,874		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,568		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,212,865	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	240,209		15
16	Equipment, at Historical Cost	124,349		16
17	Accumulated Depreciation (book methods)	(96,030)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due From Related Parties	5,925,957		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,194,485	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,407,350	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 144,028	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	762,798		29
30	Accrued Salaries Payable	135,216		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	159,393		32
33	Accrued Interest Payable	3,267		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,204,702	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,297,150		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,297,150	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,501,852	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,905,498	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,407,350	$	48

*(See instructions.)

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (281,386)	1
2	Restatements (describe):		2
3			3
4	Skokie 2 eliminiation entry & post closing entries	5,544,518	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,263,132	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(578,986)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PAID IN CAPITAL	2,221,352	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,642,366	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,905,498	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,977,328	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,977,328	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	86,335	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 86,335	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	146,554	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 146,554	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,850	28
28a	TAXABLE DIVIDENDS	837	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,687	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,212,904	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	785,114	31
32	Health Care	2,132,486	32
33	General Administration	1,687,756	33
	B. Capital Expense		
34	Ownership	837,307	34
	C. Ancillary Expense		
35	Special Cost Centers	287,359	35
36	Provider Participation Fee	61,868	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,791,890	40
41	**Income before Income Taxes (line 30 minus line 40)****	(578,986)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (578,986)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
Tax return is a combination of Skokie 1 & Skokie 2

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	9,700	10,290	$ 259,231	$ 25.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,694	32,037	877,348	27.39	3
4	Licensed Practical Nurses	60	75	1,139	15.19	4
5	Nurse Aides & Orderlies	65,281	69,205	632,585	9.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,694	2,001	22,577	11.28	8
9	Activity Director					9
10	Activity Assistants	6,972	7,541	88,529	11.74	10
11	Social Service Workers	8,425	8,825	119,224	13.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,345	22,471	234,601	10.44	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	13,226	14,428	125,784	8.72	18
19	Laundry	7,447	8,192	64,565	7.88	19
20	Administrator	3,120	3,360	102,945	30.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,950	9,608	117,085	12.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,914	188,033	$ 2,645,613 *	$ 14.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	250	$ 9,975	1-3	35
36	Medical Director	10	1,200	9-3	36
37	Medical Records Consultant	136	4,128	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	10	1,452	10-3	39
40	Physical Therapy Consultant			10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	160	4,029	12-3	45
46	Other(specify) REHABILITATION	130	5,461	10a-3	46
47	PSYCHIATRIC	165	16,500	10-3	47
48	PROGRAM CONSULTANT	138	6,925	10-3	48
49	TOTAL (lines 35 - 48)	999	$ 49,670		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	190	$ 5,702	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	190	$ 5,702		53

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AUGIE BELAY	ADMIN		$ 40,945
ANITA HERMAWN	ADMIN		62,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,945

B. Administrative - Other

Description	Amount
PREMIER MANAGEMENT-MANAGEMENT FEES	$ 474,607
TOTAL (agree to Schedule V, line 17, col. 3)	$ 474,607
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		59,431
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,431

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 34,681
Unemployment Compensation Insurance		16,118
FICA Taxes		199,341
Employee Health Insurance		129,393
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		29,903
EMPLOYEE PHYSICAL EXAMS		325
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,859
Health Care Worker Background Check	2,100
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	49,942
TRUST/FRANCHISE/CONTRIB/ETC	1,711
LICENSES & PERMITS	960
DUES & SUBSCRIPTIONS	8,166
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(1,711)
Less: Public Relations Expense	(0)
Non-allowable advertising	(37,158)
Yellow page advertising	(12,784)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,085

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
EDUCATION & SEMINARS	1,752
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,752

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	2001	$ 4,429	3	$	$ 739	$ 1,477	$ 1,477	$ 736	$	$	$	$
2	PAINTING/DECORATIN	2002	642	3			107	214	214	107			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,071		$	$ 739	$ 1,584	$ 1,691	$ 950	$ 107	$	$	$

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $4730**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **61,868**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **#REF!** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees